Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VICTORIA PHYSICAL THERAPY
601 E SAN ANTONIO SUITE 301W
VICTORIA TX 77901

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-1121-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 8/25/11 – I spoke to Belinda w/ TX Mutual – She gave me the following info – OK to eval & treat the first 14 visits or 10 wks from date of injury."

Amount in Dispute: $733.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this dispute for consideration.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2011	Physical Therapy Services – CPT Codes G0283, 97110 X 2 Units	$102.24	$0.00
September 2, 2011	Physical Therapy Services – CPT Codes G0283, 97110 X 2 Units	$102.24	$0.00
September 6, 2011	Physical Therapy Services – CPT Codes G0283, 97110 X 2 Units	$102.24	$0.00
September 7, 2011	Physical Therapy Services – CPT Codes G0283, 97110 X 2 Units	$102.24	$0.00
September 9, 2011	Physical Therapy Services – CPT Codes G0283, 97110 X 2 Units	$102.24	$0.00
September 12, 2011	Physical Therapy Services – CPT Codes G0283, 97110 X 2 Units	$102.24	$0.00
September 14, 2011	Physical Therapy Services – CPT Code 97110 X 3 Units	$125.61	$0.00
TOTAL		$733.05	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 17, 2011
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 785 – SERVICE RENDERED IS INTEGRAL TO SERVICE REQUIRING PREAUTHORIZATION. PREAUTHORIZATION NOT SOUGHT/APPROVAL NOT OBTAINED FOR THAT SERVICE.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.
   - 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.

Issues

1. Did the requestor obtain preauthorization approval for the disputed physical therapy services?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires preauthorization includes: "(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

   (i) Modalities, both supervised and constant attendance;

   (ii) Therapeutic procedures, excluding work hardening and work conditioning."

   Review of the requestor's submitted documentation finds that the requestor provided physical therapy sessions on the following dates:

   CPT Code G0283: August 31, 2011, September 2, 2011, September 6, 2011, September 7, 2011, September 9, 2011 and September 12, 2011

   CPT Code 97110: August 31, 2011, September 2, 2011, September 6, 2011, September 7, 2011, September 9, 2011, September 12, 2011 and September 14, 2011

2. Review of the submitted documentation finds that the disputed dates of service August 31, 2011, September 2, 2011, September 6, 2011, September 7, 2011, September 9, 2011, September 12, 2011 and September 14, 2011 were not preauthorized in accordance with 28 Texas Administrative Code §134.600(p). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 16, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.